Equality and Diversity Update Report/2017 WRES Position

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Trust Board paper G

Executive Summary

Context

There is an agreed Equality & Diversity Action Plan which incorporates all elements of the Equality Delivery System (patient and workforce activity), the Workforce Race Equality Standard (WRES) and the recommendations from the Trust's Diversity Task and Finish Group. An Equality and Diversity Trust Board Thinking Day took place on 12 January 2017 facilitated by Roger Kline, NHS England Joint Director of Workforce Race Equality Standard and the action plan was updated to reflect best practice.

The Trust Board are updated on progress against the Equality & Diversity Action Plan at bi-annual intervals. The previous report was presented to the Trust Board on 2 February 2017.

Questions

What progress has been made in implementing the Trust's Equality and Diversity Action Plan over the last six months (since the previous report)?
What is the Trust's current WRES Position?

Conclusions

UHL continues to declare legal compliance with the Public Sector Equality Duty as demonstrated in this report and has a range of activities and processes to evidence our position.

The WRES aims to ensure employees from Black and Minority Ethnic (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace. Since July 2015, NHS Trusts have submitted their WRES data against nine indicators of staff experience and opportunities.

To date, NHS England has published WRES data analyses for 2015 and 2016. The 2015 report highlighted gaps in workplace experience between BME and white staff in access to career opportunities and fair treatment in the workplace. The 2016 report shows that whilst there is still a long way to go, there are early green shoots of hope with regard to some indicators.

The first two years of the national WRES programme has focused on establishing the architecture for data collection, regulation against the rise and effective system alignment.

We can now hold a mirror up to ourselves on this agenda as detailed in our WRES Position included in Appendix 1 of this report. The Trust Board is asked to approve the WRES data in Appendix 1 prior uploading on the national UNIFY 2 WRES Online Data Collection System and submitting to NHS England (by the 4 August 2017).

Led by the national WRES Implementation team, the next phase of the WRES programme will build on the established foundations of data collection and analyses, and will focus upon cultural and transformational change needed across the different sectors, regions and at local level. Senior representatives of the national WRES team will attend a future Trust Board Thinking Day (date to be confirmed) in progressing the next phase.

This report was discussed with the Executive Workforce Board in July 2017 and agreement was reached on running focus group sessions with CMG Boards from September 2017 onwards (on appointment of new Equality and Diversity Trust Lead) to determine local interventions.

Input Sought

The Trust Board is asked to:-

- Commit to promoting workforce race equality and in doing so make the difference that our staff, patients and communities need and deserve;
- Approve the national WRES data submission as set out in Appendix 1 of this report; and
- Continue to support with becoming a more inclusive employer by making full use of the talents of our diverse workforce and the communities we serve;

For Reference

1. The following objectives were considered when preparing this report:

Safe, high quality, patient centred healthcare	[Yes]
Effective, integrated emergency care	[Yes]
Consistently meeting national access standards	[Yes]
Integrated care in partnership with others	[Yes]
Enhanced delivery in research, innovation & ed'	[N/A]
A caring, professional, engaged workforce	[Yes]
Clinically sustainable services with excellent facilities	[Yes]
Financially sustainable NHS organisation	[Yes]
Enabled by excellent IM&T	[Yes]

2. This matter relates to the following governance initiatives:

Organisational Risk Register	[N/A]
Board Assurance Framework	[N/A]

3. Related Patient and Public Involvement actions taken, or to be taken: Patient representative groups involved in progressing this work
4. Results of any Equality Impact Assessment, relating to this matter: [Yes]
5. Scheduled date for the next paper on this topic: [next quarter]
6. Executive Summaries should not exceed 1 page. [My paper does comply]
7. Papers should not exceed 7 pages. [My paper does not comply]

REPORT TO: **UHL Trust Board**

FROM : **Louise Tibbert, Director of Workforce and Organisational Development**

BY: **Deb Baker, Interim Project Support and Bina Kotecha, Deputy Director of Learning and Organisational Development**

DATE: **Thursday 3 August 2017**

SUBJECT: **Trust Board Equality and Diversity / 2017 WRES Position Report**

1. Introduction

University Hospitals of Leicester uses the Equality Delivery System (EDS) as its equality delivery framework. The four domains are:

- Better Health Outcomes
- Improved Patient Access and Experience
- A representative and Supportive Workforce
- Inclusive Leadership

We have drafted the first iteration of Equality Action Plan which incorporates all elements of the EDS (patient and workforce activity) and the Workforce Race Equality Standard (WRES). We have appointed a new Equality and Diversity Lead (to commence 4 September 2017) and the finalised version of this action plan will be presented to the Trust Board during October 2017 following consultation with the Trust's Workforce and OD Board and Executive Workforce Board.

2. The Purpose of this Report

This report is the second annual update report to Trust Board (previous report presented in February 2017) against the Equality & Diversity Action Plan. In addition this report provides evidence of compliance for the Leicester City Clinical Commissioning Group (CCG) of our performance against the equality requirements of the 2016-17 Quality Schedule and WRES (see Appendix 1).

Equality and Diversity baseline data (at July 2017) is set out in Appendix 2 by Ethnicity, Gender and Disability with areas of under representation summarised.

3. Workforce Equality & Diversity Update

As previously reported to the Trust Board, the areas of focus for Equality and Diversity continue to be:

- Strengthen local accountability by developing CMG diversity metrics.
- Better alignment of diversity with the Trust's 5 Year Plan.

- To implement Positive Action Interventions (as part of the Trust's Recruitment and Retention Strategy).
- Strengthen partnership working across the system around the Diversity Agenda
- Develop some targeted talent management strategies for under-represented groups.

The next iteration of the Equality and Diversity Action Plan will also incorporate key actions to address the Trust's Gender Pay Gap once the analysis and sign off of the action plan is completed. This is scheduled for November 2017.

3.1 Key highlights

3.2 Strengthen Accountability

In April last year the first BME leadership data was reported by Clinical Management Group (CMG) – and is defined as band 8a and above excluding Medical Consultants. From the data, key thresholds were developed and in 2016 all CMGs were RAG rated as red in terms of BME representation within the leadership strata. The threshold is set at 28% which equates to BME representation in the general workforce and reflective of the local community as measured in 2016-17.

The BME leadership figures, as set out in Appendix 2, from April 2017 form part of Trust's Quality and Performance Indicators under the Well Led Domain and are presented to the Leadership Community at monthly Chief Executive Briefings. There has been little in the way of significant change in the levels of BME representation. It is acknowledged that a shift in performance can take a number of years.

3.3 Quality Improvement Methodology in Renal Respiratory and Cardiovascular CMG (RRCV)

One of the biggest challenges for NHS Trusts and most private sector companies is deciding which interventions could be implemented that would have the biggest impact on shifting the position. The Clinical Director in RRCV has agreed to pilot some targeted interventions (before the end of March 2018), as set out below, to see whether they have a positive impact on the levels of BME leadership representation which currently stands at 9.5%.

- Identifying talented individuals within the CMG and creating a strong medium term talent pipeline
- Introduce Reverse Mentoring Programme
- Staff engagement focusing on the 2 WRES indicators - which include the experience of discrimination and access to training opportunities
- Unconscious Bias Awareness Sessions for recruiting managers

This work forms part of the national Quality Improvement Methodology Project led by NHS England (WRES Team) and UHL is proud to be selected to participate in this national project along with 4 other NHS Organisations. The baseline data set agreed with the national WRES Team is as follows:

- BME / White staff break down band 7/8 and above
- Friends and Family Test (FFT)
- Staff turnover
- Internal promotions
- Training data for RRCV
- Staff Survey

We are in the process of collecting the data and agreeing the sequence of the interventions following listening events in September 2017 (open to all staff although particularly targeting BME staff in RRCV). A survey is currently being undertaken (all staff within RRCV invited to participate) to assess opportunities for career progression and accessibility of development programmes/interventions.

3.4 Reverse Mentoring Scheme

The reverse mentoring scheme commenced in February 2017 with four of our Executive Directors agreeing to act as "mentees" for our 4 BME mentors. These are; Andrew Furlong Medical Director, Julie Smith Chief Nurse and Louise Tibbert Director of Workforce and Organisational Development and Suzanne Khalid CMG Clinical Director (RRCV). The principle aim of the scheme is for mentors to provide the Directors with the personal experiences of their UHL career journeys. The findings so far have been:

- The topics chosen seem to have been useful as a catalyst for the one to one discussions between Mentors and Mentees. Conversations have been centred around culture, recruitment and selection, the appraisal process, training and promotion opportunities and any experience of discrimination.
- Many useful insights have already been highlighted via this project process which can be used to review, continue and improve processes currently in place in the Trust. In one case the mentee was from a different generation and therefore the conversations have included discussions on different work and life influences across the generations.
- It is positive to note that the project is also highlighting areas of good practice in the Trust that we need to be proud of and continue to build on and/or role out elsewhere.
- The small group of Mentors are all committed to continue with the process and also develop into a steering group at the end of the process to support the Equality and OD teams in publicity, recruitment and support for this type of programme in the future.
- Mentors and mentees have engaged in discussions in differences in experiences and expectations particularly as a result of the generational gap.

The project is due to complete in August 2017 and we will provide the Trust Board with a subsequent update.

3.5 Leadership Development through the East Midlands Leadership Academy (EMLA)

The Trust is a member of the East Midlands Leadership Academy and attendance on programmes by underrepresented groups is reported and monitored at quarterly intervals. The 2016-17 Utilisation Report received from EMLA highlights BME representation on leadership programmes. The overall BME participation rate for 2016 - 2017 has improved and is currently at 18%, we note that this is 10% less than the overall workforce representation level. White 71% and unspecified 11% suggesting further improvement is required to ensure BME staff participate in external development programmes in the same proportionate numbers as White staff.

To respond to this we have created a greater awareness around national BME specific career and leadership development opportunities and as a result have secured a number of places on specific programmes such as 'Stepping Up' (as reported to the Trust Board in April 17) targeting bands 5-7.

We have encouraged our staff to contribute to the EMLA Visible Leaders Network (7 participants) which is network for BME leaders (Bands 6-8a) and offers career management development as well as support with transforming equality and diversity at an organisational level.

A new initiative from EMLA is that we now have some insight into staff that are registering interest for EMLA programmes and a suggested action from this is to monitor applications in order to better target greater representation from protected characteristic groups.

3.6 Unconscious Bias Training

Unconscious Bias training is now a supplementary module of the UHL Way Leadership Programme currently being rolled out to all middle and senior managers (offered to cohorts 1-4). Ad hoc sessions are also available on request. The CMG HR Business Partners have all been trained and are able to deliver short sessions as required within their CMGs/Corporate Areas.

We are currently drafting a People Capability Framework (Focus Groups will be held during August 2017) and the corresponding development programme and will ensure Unconscious Bias Training forms part of this. The Trust's new People Capability Framework will be launched in March 2018 following pilot in the selected area (to be confirmed).

3.7 Recruitment

The Learning and Development Team are working with Leicestershire Education Business Company (LEBC), Sector Work Based Academies, Leicester Apprenticeship Hub, and Leicester Enterprise Partnership, to promote NHS, through schools and colleges, community settings, direct mailing to year 12s and 13s across the city and county to promote health based careers within BME communities.

We are also working closely with the Trust's Patient and Public Involvement Lead in drafting a joint programme of Community Engagement ensuring UHL presence

(particularly promoting UHL career opportunities) during high profile local events such as the Leicester Mela.

3.8 LLR System-wide Interventions

As part of the Leicester Leicestershire and Rutland Sustainability and Transformation Partnership (STP), work is underway in addressing the gaps identified and set out within the triple aims of the STP. During 2017-18 partners across health and social care will explore collaboration opportunities working towards developing a joint LLR wide Equality Action Plan. The Trust's new Equality and Diversity Lead will be key to progressing this work.

In July 2017 we appointed a LLR Clinical Fellow to support with pulling together the joint action plan. Over the next 12 months our fellow will finalise the joint plan with the LLR Clinical Leadership Group and will commence with implementing interventions supported by the LLR Organisational Development and Change Group and Equality and Diversity leads employed within partner organisations.

Nationally, the WRES Team will be focusing on a culture transformation programme and will attend a Trust Board Thinking day during October/November. As part of this a WRES Legacy Development Programme will be provided (one place per STP footprint) in building WRES expertise, capacity and capability across the Health and Social Care System.

3.9 The Workforce Disability Equality Standard (WDES)

In the last 12 months NHS England and NHS Employers have been developing a Workforce Disability Equality Standard (WDES), which will be implemented formally from April 2018. The finalised standard and technical guidance is expected in September 2017. There has been an extension to the timeframe which was originally April 2017.

This standard will be similar in structure and format to the WRES, however the indicators will be slightly different. The standard offers the same opportunity as the WRES for NHS organisations to quantify the different workplace experiences and outcomes of disabled and non-disabled staff. The data will be collected nationally in April 2018 and potentially reported on later in 2018.

3.10 Workforce Race Equality Standard (WRES) 2016-17 National analysis

The WRES aims to ensure employees from black and minority ethnic (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace. Since July 2015, NHS Trusts submitted their WRES data against nine indicators of staff experience and opportunities.

To date, NHS England has published WRES data analyses for 2015 and 2016. The 2015 report highlighted gaps in workplace experience between BME and White staff in access to career opportunities and fair treatment in the workplace. The 2016 report shows that whilst there is still a long way to go, there are green shoots with regard to some indicators.

4.0 Latest WRES Position

Based on feedback from the WRES baseline data returns and from engagement with the NHS, the wording for Indicators 1 and 9 has been revised in relatively minor ways as set out in the national WRES Technical Guidance for 2017. The revisions seek to add clarity on progress against these two WRES indicator:

- WRES Indicator 1 now has a clearer definition of "senior medical manager" and "very senior manager".

- WRES Indicator 9 now requires submission of data that disaggregates: (i) the voting and non-voting members of boards, and (ii) the Executive and Non- Executive members of boards.

- With regard to WRES Indicator 2, organisation's annual data returns are expected to include the shortlisting to appointment data for both internal and external recruitment activity. This will be a challenge for many Trusts as the data isn't currently collected and not easily retrievable using ESR. UHL will need a system; the Trust's Recruitment Lead is working on a solution.

4.1 Key National Findings for 2016-17

- A higher percentages of BME staff report the experience of harassment, bullying or abuse from staff, than White staff, regardless of Trust type or geographical region. Community Provider and Ambulance Trusts are more likely to report this pattern.

- BME staff are generally less likely than White staff to report the belief that the Trust provides equal opportunities for career progression or promotion. This pattern is strikingly widespread regardless of type of Trust or geographical location.

- BME staff are more likely to report they are experiencing discrimination at work from a manager, team leader or other colleague compared to White staff, regardless of Trust type or geographical location.

- NHS Staff Survey responses from BME staff were, in a significant number of cases, too small to report. In some cases, given the demographics of the Trust or the locality served, this was surprising. NHS Trusts are strongly recommended to carry out the survey using full rather than small staff samples.

- Community Provider Trusts and Mental Health and Learning Disability Trusts generally report a higher percentage of BME staff experiencing harassment, bullying or abuse from patients, relatives or the public when compared to White staff.

In terms of analysing UHL's position the results have not been 'league tabled 'making it difficult to determine at a glance our overall position. UHL is achieving an average score for indicators 5-8 with only marginal differences between White and BME Staff. The most

marked difference for UHL is staff satisfaction with access to career opportunities with White staff declaring a 20% greater satisfaction rate than BME staff.

4.2 WRES COMPARISON ANALYSIS

4.2.1 Indicator 1 Clinical and Non - Clinical workforce representation

The general Workforce data for this year has seen a rise for BME staff in both clinical and non - clinical roles (28%-30%). A further rise has occurred in BME Medical representation which now stands at 51%.

4.2.2 Indicator 2 - Recruitment Data

Historically for most organisations there has been a marked difference in terms of recruitment outcome for White and BME staff. Whilst UHL has successfully recruited BME staff in representative numbers (currently 30%), the conversion rate from shortlisting to appointment has favoured White applicants. The shortlisting to appointment data for BME staff is showing an improved position. Going forward there is a requirement to monitor internal promotions as well as external recruitment activity. We are currently unable to accurately track internal promotions by ethnicity via ESR or TRAC (UHL Recruitment System) and work is underway in resolving this.

We note significant gaps in employment declaration for Equality Data and plan to address this as we improve systems and processes.

4.2.3 Indicator 3 – Disciplinary Cases

Nationally BME staff are generally over represented in formal disciplinary cases. However our figure for this year shows proportionate numbers for BME and White staff entering the disciplinary process.

4.2.4 Indicator 4 - Access to Non-Mandatory Training

Non mandatory training includes the following types of Professional Development. We would expect that BME and White staff would access training opportunities in proportionate numbers.

- Leadership Development
- Qualifications and Credit Framework (QCF) Programmes
- Day courses (non-accredited)
- Apprenticeships

Attendance for all training by BME staff is under-representative at **19%.** However, attendance at Leadership courses for BME staff is **32%** which demonstrates a significant improving position.

The undisclosed rate for UHL based training is 21% which is very high making accurate trend analysis difficult. We therefore need to ensure course participants complete their equality monitoring forms before enrolment is confirmed**.**

4.2.5 Indicator 5 - Experience of harassment from patients

2017 data shows a reduction for both White and BME staff. The trend however, shows that White staff report a marginally higher rate (1% more) of harassment from patients than BME staffs

4.2.6 Indicator 6 - Experience of harassment from staff

2017 shows a 5% reduction from the previous year, however the trend remains the same in that BME staff experience slightly more harassment than White staff from other staff. Bullying and harassment information is collected and there is no evidence to suggest that BME staff are overrepresented in the Trust figures.

4.2.7 Indicator 7- Career Progression

A higher percentage of White staff believe that they have equal opportunity for career progression at UHL than BME staff. The data for 2017 is showing deterioration in the level of satisfaction for BME staff and therefore warrants a bespoke piece of work looking at barriers to career progression. A survey has been developed and is being piloted RRCV. Results will be available in September /October 2017 and will be used to steer future interventions.

4.2.8 Experience of Discrimination form Managers/Colleagues

Although showing a downward trend BME staff are still twice as likely to experience discrimination than White staff. A discrimination question has been included in the staff questionnaire currently being piloted within RRCV.

4.2.9 Summary Position

Generally the WRES data is showing an improved position for 7 of the indicators with a deterioration in the two listed below. More detail can be found at **Appendix 1.**

- BME staffs experience of career progression
- BME staff accessing Non - Mandatory training

5.0 Patient Access and Health Outcome Activity

5.1 Interpreter Service

In March 2017 the incumbent interpreting provider, Pearl Linguistics liquidated and ceased trading leaving UHL and many other Trusts without any interpreting service. Within 24 hours Language Line a telephone interpreting company was able to supply a service to us. At this point we were unable to provide a face to face service, whilst this wasn't ideal from

a patient and user perspective, it is a clinically safe option. Using the telephone is not popular with some Clinicians and whilst it is fair to say that there are some circumstances whereby telephone interpreting is inappropriate such as breaking bad news, the main barrier to using it effectively is having access to the right equipment in the right place i.e. a cordless speaker phone.

The Trust spent nearly £450k on Interpreting Services in 2015-16 with a year on year increase in usage of which 90% is provided face to face. There is an opportunity for savings if some of the Interpreting activity transfers to telephone. Particularly in relation to those sessions that are less than 30 minutes long (this occurs commonly in Outpatients). To successfully transfer even 20% of activity via the telephone it will be dependent on Clinicians having the right technology at their fingertips to enable easy and quick access to the service. UHL has asked as part of the tender process for the new contract how the suppliers will support the Trust in shifting some of the activity from face to face to telephone. It is hoped that because we have been heavily reliant on the telephone service since March 2017 that some of the resistance may have diminished and staff will be more amenable to conducting consultations where clinically appropriate via the telephone. A fully worked up model will be drawn up as part of the mobilisation process.

5.1.1 Access to British Sign language for Deaf Patients

In terms of interpreting services for deaf patients we approached our two local British Sign Language interpreting providers and agreed that they will provide our BSL service for one year in the first instance. We know from previous engagement with the Deaf Community that access to BSL across the health sector remains inconsistent and that Deaf people by large would prefer a locally based BSL service. The Equality Lead is working with Procurement and our local BSL suppliers to build a more timely and responsive system. Feedback from the community to date suggests that the new system is working very well for them. Previous concerns regarding the capacity of the local providers have not been realised during the initial period (March 2017 – to date), with 98% bookings made filled.

The tendering process is underway with six Interpreting and Translation companies submitted tenders followed up with a presentation to the Equality Team, Procurement and representatives from the CMGs. We are in the process of evaluation to identify our preferred bidder. We are planning to award and mobilise the contract by the end of August 2017.

5.2 The Accessible Information Standard

NHS England has introduced the Accessible Information Standard (AIS) in all organisations that provide NHS or Adult Social Care. Work is progressing and an IT solution is now available in Outpatients that will enable staff to record patient's information requirements. The IT system is also ready to go in inpatients services, however, we need to identify and communicate to staff how the data will be collected and inputted, following the appropriate upgrading of Nerve Centre. There is still some work to do in terms of the

system being able to automatically generate information in the patients required format. This appears to be the position that most Trusts are in currently. IM&T have set up a facility on HISS to record patients' communications needs.

- Information in Braille
- Information in large print
- British Sign Language Interpreter
- Correspondence via text
- Correspondence via telephone
- Correspondence via email
- Information in Easy Read
- Foreign language interpreter
- Speech to text reporter
- Other Lip speaker
- Note taker

Further work is required to ensure full compliance is to:

- Develop some staff guidance
- Develop the facility within Nerve Centre for inpatients
- Develop a communication plan for staff and patients.

5.3 Disability Patient Data Collection

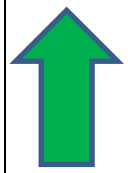
Since May 2016 the Trust has collected disability status from patients. In May the data recording rate was 4.4%. This has risen to 15.6% as of November 2016. There is clearly some way to go but the data is showing a month by month increase. The purpose of doing this is to quantify any differences in the levels of access to our services. We plan to report in January 2018 our Do Not Attend (DNA) rate and referral to treatment rates by Gender, Disability and Ethnicity.

Workforce Race Equality Standard (WRES) Comparison Data for April 2016–17

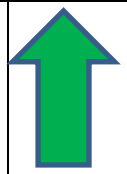
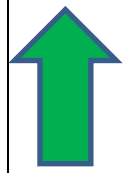
<table>
<tr><th>WRES Indicator</th><th>2015-16</th><th>2016-17</th><th>Summary position</th><th>Compared to previous year</th></tr>
<tr>
<td>1.Percentage of staff in each of the AfC Bands 1-9 or Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce disaggregated by:

• Non-Clinical staff
• Clinical staff - of which
- Non-Medical staff
- Medical and Dental staff</td>
<td>
<table>
<tr><th></th><th>BME</th><th>Unspec</th><th>White</th></tr>
<tr><td>Non Clinical Staff Total</td><td>25.52</td><td>2.35</td><td>72.13</td></tr>
<tr><td></td><td></td><td></td><td></td></tr>
<tr><td>Clinical Staff Total</td><td>28.78</td><td>4.13</td><td>67.09</td></tr>
<tr><td>Non-Medical</td><td>23.88</td><td>3.57</td><td>72.55</td></tr>
<tr><td>Medical</td><td>49.44</td><td>6.51</td><td>44.04</td></tr>
<tr><td></td><td></td><td></td><td></td></tr>
<tr><td>All Staff Total</td><td>24.32</td><td>3.24</td><td>72.44</td></tr>
</table>
</td>
<td>
<table>
<tr><th></th><th>BME</th><th>Unspec</th><th>White</th></tr>
<tr><td>Non Clinical Staff Total</td><td>30.16</td><td>1.54</td><td>68.30</td></tr>
<tr><td></td><td></td><td></td><td></td></tr>
<tr><td>Clinical Staff Total</td><td>30.69</td><td>2.27</td><td>67.04</td></tr>
<tr><td>Non-Medical</td><td>25.70</td><td>1.70</td><td>72.60</td></tr>
<tr><td>Medical</td><td>51.19</td><td>4.61</td><td>44.20</td></tr>
<tr><td></td><td></td><td></td><td></td></tr>
<tr><td>All Staff Total</td><td>30.53</td><td>2.04</td><td>67.43</td></tr>
</table>
</td>
<td>There is an increase in the numbers of BME staff in both non - clinical and clinical roles.

BME representation in senior positions (band 8a and above) remains an area of focus

9% Senior Manager in 2016 and increased to 12% in 2017</td>
<td>  </td>
</tr>
<tr>
<td rowspan="2">2. Relative likelihood of staff being appointed from shortlisting across all posts

Note: This refers to both externally and internally advertised posts</td>
<td><u>White</u>
Shortlisted 46%</td>
<td><u>BME</u>
Shortlisted 51%</td>
<td><u>White</u>
Shortlisted 45%</td>
<td><u>BME</u>
Shortlisted 52%</td>
<td rowspan="2">The shortlisting to appointment data for BME staff is showing an improved position for 2016-17.

Work underway in recording internal promotion/movement</td>
<td rowspan="2">  </td>
</tr>
<tr>
<td>Appointed 62%</td>
<td>Appointed 32.8%</td>
<td>Appointed 59%</td>
<td>Appointed 38%</td>
</tr>
<tr>
<td>3. Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation
Note: This indicator will be based on data from a two year rolling average of the current year and the previous year</td>
<td><u>White</u>
60%</td>
<td><u>BME</u>
31%</td>
<td><u>White</u>
68.5%</td>
<td><u>BME</u>
28.5 %
(positive reduction)</td>
<td>Nationally BME staff are over represented in formal disciplinary cases. This year proportionate numbers for BME and White staff demonstrating an improving position.</td>
<td>  </td>
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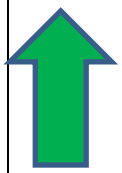
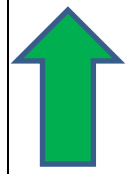
Workforce Race Equality Standard (WRES) Comparison Data for April 2016–17

WRES Indicator	2015-16		2016-17		Summary Position	Compared to previous year
4. Relative likelihood of BME staff accessing non-mandatory training and CPD as compared to White staff	White 68%	BME 20%	White 57%	BME 19%	Attendance for **all** training by BME staff is under-representative at 19%. Attendance at Leadership courses for BME staff is **32%** which demonstrates an improving position. *The undisclosed rate for UHL based training is 21% making accurate trend analysis difficult.*	
5. National Staff Survey Key Finding - Percentage of staff experiencing harassment, bullying or abuse from patients in last 12 months	White 33.5%	BME 30.23%	White 22%	BME 21%	2017 data shows a reduction for both White and BME staff. The trend however, shows that White staff report a marginally higher rate of harassment from patients than BME staff.	
6. National Staff Survey Key Finding - Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	White 28.22%	BME 28.57%	White 23.05%	BME 24.18%	2017 shows a reduction from the previous year however the trend remains the same in that BME staff experience slightly more harassment than white staff.	

Workforce Race Equality Standard (WRES) Comparison Data for April 2016–17

WRES Indicator	2015-16		2016-17		Summary Position	Compared to previous year
7. National Staff Survey Key Finding - Percentage believing that Trust provides equal opportunities for career progression or promotion	White 93.44%	BME 85.19%	White 86%	BME 76%	A higher % of White staff believe that they have equal opportunity for career progression at UHL than BME staff. The data for 2017 is showing deterioration in the level of satisfaction across BME respondents	
8. National Staff Survey Key Finding- In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues	White 8.59%	BME 19%	White 5.3%	BME 10.23%	Although showing an upward trend BME staff are twice as likely to experience discrimination than White staff.	
9.Percentage difference between the organisations' Board membership and its overall workforce disaggregated: • By voting membership of the Board • By Executive membership of the Board Note: this is an amended version of the previous definition of Indicator 9	White 86% (Board) 83% 100%	BME 28% (general workforce) 14% (Board) 17% 0%	White 86% (Board) 83% 100%	BME 30% (general Workforce) 14% (Board) 17% 0%	No change from the previous year	

Ethnicity

			Leadership exc Med Consultants	
	Heads	%	Heads	%
BME	4575	30.72%	85	12.20%
Not stated	305	2.05%	20	2.87%
White	10011	67.23%	592	84.94%
Total	14891	100.00%	697	100.00%
Alliance Elective Care BME	26	8.02%	4	25.00%
Not stated	6	1.85%	0	0.00%
White	292	90.12%	12	75.00%
CHUGGS BME	432	33.62%	7	13.46%
Not stated	16	1.25%	1	1.92%
White	837	65.14%	44	84.62%
Clinical Support & Imaging Services BME	691	30.60%	26	17.33%
Not stated	52	2.30%	9	6.00%
White	1515	67.09%	115	76.67%
Corporate BME	866	32.80%	19	10.38%
Not stated	54	2.05%	5	2.73%
White	1720	65.15%	159	86.89%
Emergency & Specialist Medicine BME	682	35.84%	7	8.64%
Not stated	30	1.58%	0	0.00%
White	1191	62.59%	74	91.36%
Emergency & Specialist Medicine Total	1903	12.78%	81	100.00%
ITAPS BME	465	34.83%	5	14.71%
Not Stated	35	2.62%	1	2.94%
White	835	62.55%	28	82.35%
MSK & Specialist Surgery BME	418	35.91%	5	11.63%
Not stated	26	2.23%	0	0.00%
White	720	61.86%	38	88.37%
RRCV BME	555	28.67%	6	8.00%
Not stated	44	2.27%	2	2.67%
White	1337	69.06%	67	89.33%
Women's & Children's BME	440	21.51%	6	9.52%
Not stated	42	2.05%	2	3.17%
	1564	76.44%	55	87.30%

All areas are below the Trust average BME representation of 30.72%. With Women's and Children's, MSSK, ESM, Corporate below the current Trust Leadership BME representation of 12.2%

Gender

	Gender	Overall WF Total		Leadership exc Med Consultants	
		Heads	%	Heads	%
	Female	11447	76.87%	453	64.99%
	Male	3444	23.13%	244	35.01%
	Grand Total	14891	100.00%	697	100.00%
Alliance Elective Care	Female	288	88.89%	13	81.25%
	Male	36	11.11%	3	18.75%
CHUGGS	Female	1033	80.39%	35	67.31%
	Male	252	19.61%	17	32.69%
Clinical Support & Imaging Services	Female	1631	72.23%	103	68.67%
	Male	627	27.77%	47	31.33%
Corporate	Female	1773	67.16%	99	54.10%
	Male	867	32.84%	84	45.90%
Emergency & Specialist Medicine	Female	1470	77.25%	58	71.60%
	Male	433	22.75%	23	28.40%
ITAPS	Female	1003	75.13%	23	67.65%
	Male	332	24.87%	11	32.35%
MSK & Specialist Surgery	Female	871	74.83%	28	65.12%
	Male	293	25.17%	15	34.88%
RRCV	Female	1536	79.34%	44	58.67%
	Male	400	20.66%	31	41.33%
Women's & Children's	Female	1842	90.03%	50	79.37%
	Male	204	9.97%	13	20.63%

Women are under represented at the leadership level (64.99%) compared to the overall Trust representation of 76.87%. RRCV are below the Trust current level of female representation at a leadership level (58.67%).

Disability

	Disabled	Overall WF Total		Leadership exc Med Consultants	
		Heads	%	Heads	%
	No	11640	78.17%	539	77.33%
	Not Declared	568	3.81%	16	2.30%
	Undefined	2133	14.32%	132	18.94%
	Yes	550	3.69%	10	1.43%
Alliance Elective Care	No	266	82.10%	13	81.25%
	Not Declared	46	14.20%	3	18.75%
	Undefined	3	0.93%	0	0.00%
	Yes	9	2.78%	0	0.00%
CHUGGS	No	975	75.88%	41	78.85%
	Not Declared	49	3.81%	1	1.92%
	Undefined	216	16.81%	10	19.23%
	Yes	45	3.50%	0	0.00%
Clinical Support & Imaging Services	No	1759	77.90%	119	79.33%
	Not Declared	39	1.73%	3	2.00%
	Undefined	387	17.14%	27	18.00%
	Yes	73	3.23%	1	0.67%
Corporate	No	2318	87.80%	152	83.06%
	Not Declared	48	1.82%	2	1.09%
	Undefined	131	4.96%	25	13.66%
	Yes	143	5.42%	4	2.19%
Emergency & Specialist Medicine	No	1483	77.93%	55	67.90%
	Not Declared	107	5.62%	5	6.17%
	Undefined	238	12.51%	21	25.93%
	Yes	75	3.94%	0	0.00%
ITAPS	No	960	71.91%	20	58.82%
	Not Declared	90	6.74%	0	0.00%
	Undefined	246	18.43%	11	32.35%
	Yes	39	2.92%	3	8.82%
MSK & Specialist Surgery	No	889	76.37%	29	67.44%
	Not Declared	41	3.52%	1	2.33%
	Undefined	199	17.10%	12	27.91%
	Yes	35	3.01%	1	2.33%
RRCV	No	1471	75.98%	60	80.00%
	Not Declared	81	4.18%	0	0.00%
	Undefined	324	16.74%	14	18.67%
	Yes	60	3.10%	1	1.33%
Women's & Children's	No	1519	74.24%	50	79.37%
	Not Declared	67	3.27%	1	1.59%
	Undefined	389	19.01%	12	19.05%
	Yes	71	3.47%	0	0.00%

Disabled employees are under represented at the leadership level 1.43% compared to the Trust overall representation of 3.69%. Those CMGs below the Trust level of 1.43% are Alliance, CHUGGS, CSI, ESM, RRCV and women's and children's.